

**Continuing Care Retirement Community
Disclosure Statement
General Information**

Date Prepared: _____

FACILITY NAME: _____
 ADDRESS: _____ ZIP CODE: _____ PHONE: _____
 PROVIDER NAME: _____ FACILITY OPERATOR: _____
 RELATED FACILITIES: _____ RELIGIOUS AFFILIATION: _____
 YEAR OPENED: _____ NO. OF ACRES: _____ MULTI-STORY: _____ SINGLE STORY: _____ BOTH: _____
 MILES TO SHOPPING CTR: _____ MILES TO HOSPITAL: _____

NUMBER OF UNITS:	INDEPENDENT LIVING	HEALTH CARE
APARTMENTS - STUDIO _____	APARTMENTS – 1 BDRM _____	ASSISTED LIVING _____
APARTMENTS – 1 BDRM _____	APARTMENTS – 2 BDRM _____	SKILLED NURSING _____
APARTMENTS – 2 BDRM _____	COTTAGES/HOUSES _____	SPECIAL CARE _____
COTTAGES/HOUSES _____	% OCCUPANCY AT YEAR END _____	DESCRIBE SPECIAL CARE: _____

TYPE OF OWNERSHIP: ☐ NOT FOR PROFIT ☐ FOR PROFIT ACCREDITED: ☐ Y ☐ N BY: _____

FORM OF CONTRACT: ☐ LIFE CARE ☐ CONTINUING CARE ☐ FEE FOR SERVICE
☐ ASSIGN ASSETS ☐ EQUITY ☐ ENTRY FEE ☐ RENTAL

REFUND PROVISIONS (Check all that apply): ☐ 90% ☐ 75% ☐ 50% ☐ PRORATED TO 0% ☐ OTHER: _____

RANGE OF ENTRANCE FEES: \$_____ TO \$_____ **LONG-TERM CARE INSURANCE REQUIRED?** ☐ Y ☐ N

HEALTH CARE BENEFITS INCLUDED IN CONTRACT: _____

ENTRY REQUIREMENTS: MIN. AGE: _____ PRIOR PROFESSION: _____ OTHER: _____

FACILITY SERVICES AND AMENITIES

COMMON AREA AMENITIES	SERVICES AVAILABLE		INCLUDED IN FEE	FOR EXTRA CHARGE
	AVAILABLE	FEE FOR SERVICE		
BEAUTY/BARBER SHOP	<input type="checkbox"/>	<input type="checkbox"/>	HOUSEKEEPING TIMES/MONTH	_____
BILLIARD ROOM	<input type="checkbox"/>	<input type="checkbox"/>	NUMBER OF MEALS/DAY	_____
BOWLING GREEN	<input type="checkbox"/>	<input type="checkbox"/>	SPECIAL DIETS AVAILABLE	_____
CARD ROOMS	<input type="checkbox"/>	<input type="checkbox"/>		
CHAPEL	<input type="checkbox"/>	<input type="checkbox"/>	24-HOUR EMERGENCY RESPONSE	<input type="checkbox"/>
COFFEE SHOP	<input type="checkbox"/>	<input type="checkbox"/>	ACTIVITIES PROGRAM	<input type="checkbox"/>
CRAFT ROOMS	<input type="checkbox"/>	<input type="checkbox"/>	ALL UTILITIES EXCEPT PHONE	<input type="checkbox"/>
EXERCISE ROOM	<input type="checkbox"/>	<input type="checkbox"/>	APARTMENT MAINTENANCE	<input type="checkbox"/>
GOLF COURSE ACCESS	<input type="checkbox"/>	<input type="checkbox"/>	CABLE TV	<input type="checkbox"/>
LIBRARY	<input type="checkbox"/>	<input type="checkbox"/>	LINENS FURNISHED	<input type="checkbox"/>
PUTTING GREEN	<input type="checkbox"/>	<input type="checkbox"/>	LINENS LAUNDERED	<input type="checkbox"/>
SHUFFLEBOARD	<input type="checkbox"/>	<input type="checkbox"/>	MEDICATION MANAGEMENT	<input type="checkbox"/>
SPA	<input type="checkbox"/>	<input type="checkbox"/>	NURSING/WELLNESS CLINIC	<input type="checkbox"/>
SWIMMING POOL-INDOOR	<input type="checkbox"/>	<input type="checkbox"/>	PERSONAL NURSING/HOME CARE	<input type="checkbox"/>
SWIMMING POOL-OUTDOOR	<input type="checkbox"/>	<input type="checkbox"/>	TRANSPORTATION-PERSONAL	<input type="checkbox"/>
TENNIS COURT	<input type="checkbox"/>	<input type="checkbox"/>	TRANSPORTATION-PREARRANGED	<input type="checkbox"/>
WORKSHOP	<input type="checkbox"/>	<input type="checkbox"/>	OTHER _____	<input type="checkbox"/>
OTHER _____	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

All providers are required by Health and Safety Code section 1789.1 to provide this report to prospective residents before executing a deposit agreement or continuing care contract, or receiving any payment. Many communities are part of multi-facility operations which may influence financial reporting. Consumers are encouraged to ask questions of the continuing care retirement community that they are considering and to seek advice from professional advisors.

PROVIDER NAME: _____

CCRCs	LOCATION (City, State)	PHONE (with area code)
MULTI-LEVEL RETIREMENT COMMUNITIES		
FREE-STANDING SKILLED NURSING		
SUBSIDIZED SENIOR HOUSING		

*** PLEASE INDICATE IF THE FACILITY IS LIFE CARE.**

PROVIDER NAME: _____

	1998	1999	2000	2001
INCOME FROM ONGOING OPERATIONS				
OPERATING INCOME				
(excluding amortization of entrance fee income)	_____	_____	_____	_____
LESS OPERATING EXPENSES				
(excluding depreciation, amortization, & interest)	_____	_____	_____	_____
NET INCOME FROM OPERATIONS	_____	_____	_____	_____
LESS INTEREST EXPENSE	_____	_____	_____	_____
PLUS CONTRIBUTIONS	_____	_____	_____	_____
PLUS NON-OPERATING INCOME (EXPENSES)				
(excluding extraordinary items)	_____	_____	_____	_____
NET INCOME (LOSS) BEFORE ENTRANCE FEES, DEPRECIATION AND AMORTIZATION	=====	=====	=====	=====
NET CASH FLOW FROM ENTRANCE FEES				
(Total Deposits Less Refunds)	=====	=====	=====	=====

DESCRIPTION OF SECURED DEBT AS OF MOST RECENT FISCAL YEAR END

LENDER	OUTSTANDING BALANCE	INTEREST RATE	DATE OF ORIGINATION	DATE OF MATURITY	AMORTIZATION PERIOD
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

FINANCIAL RATIOS (see next page for ratio formulas)

	1999 CCAC Medians 50 th Percentile (optional)	1999	2000	2001
DEBT TO ASSET RATIO	_____	_____	_____	_____
OPERATING RATIO	_____	_____	_____	_____
DEBT SERVICE COVERAGE RATIO	_____	_____	_____	_____
DAYS CASH-ON-HAND RATIO	_____	_____	_____	_____

HISTORICAL MONTHLY SERVICE FEES

AVERAGE FEE AND PERCENT CHANGE

	1998	%	1999	%	2000	%	2001
STUDIO	_____	_____	_____	_____	_____	_____	_____
ONE BEDROOM	_____	_____	_____	_____	_____	_____	_____
TWO BEDROOM	_____	_____	_____	_____	_____	_____	_____
COTTAGE/HOUSE	_____	_____	_____	_____	_____	_____	_____
ASSISTED LIVING	_____	_____	_____	_____	_____	_____	_____
SKILLED NURSING	_____	_____	_____	_____	_____	_____	_____
SPECIAL CARE	_____	_____	_____	_____	_____	_____	_____

COMMENTS FROM PROVIDER: _____

PROVIDER NAME: _____

FINANCIAL RATIO FORMULAS

LONG-TERM DEBT TO TOTAL ASSETS RATIO

$$\frac{\text{Long-Term Debt, less Current Portion}}{\text{Total Assets}}$$

OPERATING RATIO

$$\frac{\begin{array}{l} \text{Total Operating Expenses} \\ \text{-- Depreciation Expense} \\ \text{-- Amortization Expense} \end{array}}{\begin{array}{l} \text{Total Operating Revenues} \\ \text{-- Amortization of Deferred Revenue} \end{array}}$$

DEBT SERVICE COVERAGE RATIO

$$\frac{\begin{array}{l} \text{Total Excess of Revenues over Expenses} \\ \text{+ Interest, Depreciation,} \\ \text{and Amortization Expenses} \\ \text{-- Amortization of Deferred Revenue} \\ \text{+ Net Proceeds from Entrance Fees} \end{array}}{\text{Annual Debt Service}}$$

DAYS CASH ON HAND RATIO

$$\frac{\begin{array}{l} \text{Unrestricted Current Cash} \\ \text{And Investments} \\ \text{+ Unrestricted Non-Current Cash} \\ \text{and Investments} \end{array}}{(\text{Operating Expenses} - \text{Depreciation} - \text{Amortization})/365}$$

Note: These formulas are also used by the Continuing Care Accreditation Commission. For each formula, that organization also publishes annual median figures for certain continuing care retirement communities.